Employee ID #: 811

Employee Health Initiatives
Group Insurance Qualified Status Change Form

Please Print

Required Information

Complete this form within 30 days of a Qualified Status Change and deliver it to the Employee Health Initiatives Office or your HR Liaison.

Employee Demographic Information Section

Last Name	First Name	Middle Initial	Date of Birth

Gender	Social Security # (voluntary)	Alternate ID # Request	Marital Status	Dept. Name
○ Male ○ Female		○ No ○ Yes Form	○ Single ○ Married ○ Divorced ○ Widow	

Mailing Address	City	State	Zip
		AZ	

E-mail Address	Home Phone #	Work Phone #	Mobile Phone #

Emergency Contact Name	Emergency Contact Phone #	Emergency Contact Address

Is your spouse a Maricopa County employee? ○ Yes ○ No

If yes, please include Employee ID for spouse: 811

CHANGE REASON SECTION (Please Check One Reason to Explain Your Status Change)

- ○ Marriage
- ○ Birth
- ○ Adoption
- ○ Placement for adoption
- ○ Legal guardianship of child
- ○ Qualified Medical Child Support order
- ○ Change in legal custody
- ○ Return from unpaid leave
- ○ Return from military leave
- ○ Divorce
- ○ Annulment
- ○ Legal separation
- ○ Dependent child reaches age 19

Dependent student
- ○ Began full-time higher education
- ○ Ended full-time higher education
- ○ Reached age 25

- ○ Termination of employment
- ○ Change in hours/status results in attaining benefit eligibility
- ○ Change in hours/status results in loss of benefit eligibility
- ○ Significant cost or benefit change in spouse's employer group insurance plan (open enrollment)
- ○ Death of _____
- ○ Other _____

- ○ Began employment

Began unpaid leave of absence
- ○ Medical
- ○ Personal
- ○ Military

Attained eligibility for
- ○ Medicare
- ○ AHCCCS/Medicaid

Indicate who employment change is for ○ Employee ○ Spouse

Date of Change:

What action are you requesting? ○ Add dependent? ○ Drop dependent? ○ Drop or decline coverage for employee? ○ Other? _____

WAIVE MEDICAL COVERAGE/REQUEST MEDICAL WAIVER PAYMENT/ELECT VISION ONLY FOR WAIVER

☐ WAIVE MEDICAL Reason: _____

☐ REQUEST MEDICAL WAIVER PAYMENT To qualify for waiver payment, you must provide a copy of your current group health insurance ID card to the Employee Health Initiatives Office and work a minimum of 30 hours per week. Coverage under AHCCCS does not qualify for waiver payment. You may elect Vision Only coverage if you waive medical coverage.

☐ Elect Vision Only for Waiver

Level of Coverage
- ○ Employee
- ○ Employee & Spouse
- ○ Employee & Child(ren)
- ○ Family

ELECT A MEDICAL PLAN - Medical plans include vision and behavioral health coverage. Please choose a medical plan and the level of coverage.

- ○ CMG High Option (Coverage restricted to CIGNA clinics)
- ○ CMG Low Option (Coverage restricted to CIGNA clinics)
- ○ OAP In-Network
- ○ OAP High Option
- ○ OAP Low Option
- ○ Choice Fund High Deductible Plan with Health Savings Account

Level of Coverage
- ○ Employee
- ○ Employee & Spouse
- ○ Employee & Child(ren)
- ○ Family

ELECT A PHARMACY PLAN - Choose a Pharmacy Plan to accompany your elected Medical Plan. Do not make an election if you enrolled in the Choice Fund plan.

○ Co-Insurance Plan ○ Consumer Choice Plan

TOBACCO USER (Applies to all covered members) ○ Yes ○ No	If you enroll in a medical plan, you must indicate if you or your covered dependents are a tobacco user. If you leave this question blank, it will be assumed that you are a tobacco user and you will be charged a higher premium rate. Tobacco user means the occasional or regular use of a tobacco product including but not limited to cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco. If you or your dependents have used any tobacco products in the last 6 consecutive months, you must choose Tobacco User-Yes.
Biometric Screening ○ Yes ○ No	If you enroll in a medical plan, you must indicate if you have completed the biometric screening. If you leave this question blank, it will be assumed that you did not complete the biometric screening and will be charged a higher premium rate.
Health Risk Assessment ○ Yes ○ No	If you enroll in a medical plan, you must indicate if you have completed the health risk assessment questionnaire. If you leave this question blank, it will be assumed that you did not complete the health risk assessment questionnaire and will be charged a higher premium rate.

ELECT A DENTAL PLAN – You may elect dental coverage even if you decline medical coverage.

☐ DECLINE DENTAL PLANS	○ CIGNA Dental	○ Delta Dental	○ Employers Dental Services

Level of Coverage
- ○ Employee
- ○ Employee & Spouse
- ○ Employee & Child(ren)
- ○ Family

Employee ID # 811

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

The Health Care Flexible Spending Account (FSA) reimburses for certain health care expenses not covered by insurance. The Plan Year contribution is limited to $5,200. The full Plan Year has 26 pay periods and runs from July 1-June 30. Enter the amount (Annual Pledge) you are electing for the remainder of the plan year. Your Annual Pledge will be divided by the number of pay periods remaining in the Plan Year after your election has been processed. If you terminate employment prior to the end of the Plan Year, your Plan Year ends on the last day of the pay period in which you made a contribution. You can elect to continue this benefit through COBRA through the end of the current Plan Year.

○Add FSA ○Drop FSA ○Change FSA Amount $_____ Annual Pledge

CHILD DAY CARE or ELDER CARE FLEXIBLE SPENDING ACCOUNT (FSA)

The Dependent Care Flexible Spending Account (FSA) reimburses for dependent care (childcare or elder day care) expenses. Calendar Year contributions are limited to $5,000. However, if you are married and file a separate tax return, the maximum annual contribution is limited to $2,500 or the lesser of your earned incomes. The full Plan Year has 26 pay periods and runs from July 1-June 30. Enter the amount (Annual Pledge) you are electing for the remainder of the Plan Year. Your Annual Pledge will be divided by the number of pay periods remaining in the Plan Year after your election has been processed. If you terminate employment prior to the end of the Plan Year, your Plan Year ends on the last day of the pay period in which you made a contribution. This benefit may not be continued through COBRA. Please note this benefit may not be used to cover your dependents' health care expenses.

○Add FSA ○Drop FSA ○Change FSA Amount $_____ Annual Pledge

LIMITED USE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) This option is only available if you are enrolled in the Choice Fund plan

○Add FSA ○Drop FSA ○Change FSA Amount $_____ Annual Pledge

Please Indicate Tax Status: ○ Single ○ Married filing Jointly ○ Married filing Separately

LIFE INSURANCE SECTION - Please make sure that you have fully completed the date of birth, gender and mailing address information for each beneficiary in the Dependent / Beneficiary Information Section.

BASIC LIFE with Accidental Death & Dismemberment (AD&D) 1 X Salary (Paid 100% by Maricopa County)

Beneficiary Designation Your spouse is entitled to 50% of the value of your basic &/or supplemental life policy unless your spouse signs a spousal waiver located on the Beneficiary Designation form.

Primary Beneficiary	Whole Percentage (Must add up to 100%)	Contingent (Secondary) Beneficiary	Whole Percentage (Must add up to 100%)
1.		1.	
2.		2.	
3.		3.	

EMPLOYEE ADDITIONAL LIFE (Paid 100% by Employee)

○ Smoker ○ Non-Smoker ☐ DECLINE SUPPLEMENTAL LIFE

Plan Level Options Please Choose One ➔ ○1 X Salary ○2 X Salary ○3 X Salary ○4 X Salary ○5 X Salary

Primary Beneficiary	Whole Percentage (Must add up to 100%)	Contingent (Secondary) Beneficiary	Whole Percentage (Must add up to 100%)
1.☐Same as above	☐Same as above	1.☐Same as above	☐Same as above
2.☐Same as above	☐Same as above	2.☐Same as above	☐Same as above
3.☐Same as above	☐Same as above	3.☐Same as above	☐Same as above

ADDITIONAL AD&D Coverage (Paid 100% by Employee)

○ EE Only ○ EE & Family ☐ DECLINE AD&D COVERAGE

Plan Level Options Please Choose One ➔ ○1 X Salary ○2 X Salary ○3 X Salary ○4 X Salary ○5 X Salary

Primary Beneficiary	Whole Percentage (Must add up to 100%)	Contingent (Secondary) Beneficiary	Whole Percentage (Must add up to 100%)
1.☐Same as above	☐Same as above	1.☐Same as above	☐Same as above
2.☐Same as above	☐Same as above	2.☐Same as above	☐Same as above
3.☐Same as above	☐Same as above	3.☐Same as above	☐Same as above

DEPENDENTS LIFE (Paid100% by Employee)

*See Eligible Dependent Section for age limits Total cannot exceed employee combined Basic and Supplemental coverage

☐ DECLINE DEPENDENTS LIFE

Plan Level Options for Dependent Children Please Choose One ➔ ○$5,000.00 ○$10,000.00 ○$15,000.00* ○$20,000.00*

Plan Level Options for Spouse Please Choose One ➔

○$10,000.00	○$20,000.00	○$30,000.00
○$40,000.00	○$50,000.00	○$60,000.00*
○$70,000.00*	○$80,000.00*	○$90,000.00*
○$100,000.00*	* Evidence of insurability application required	

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Please Print

DEPENDENT / BENEFICIARY INFORMATION SECTION

In this section, you can add or drop dependents for your Medical and Pharmacy (Rx) Plan and/or for your dental plan. Please make sure you are adding eligible dependents as defined above. You must submit documentation of your status change, such as birth certificate for a newborn child, marriage certificate, divorce decree, student status verification, job status change, etc. You may also add or change your life insurance beneficiary in this section. If you have more than 5 dependents or beneficiaries, you may add them by photocopying, completing and attaching an additional copy of this page to your form.

Eligible dependents include:

- Legal spouse as defined by the State of Arizona (Domestic partners/significant others/common law spouses are not eligible)
- Unmarried child (natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship) under age 19 who resides with you more than 50% of the tax year (Qualified Medical Child Support Orders or other court/administrative orders do not violate this residency rule) and for whom you have or will provide more than 50% of his/her support during the tax year
- Unmarried child, of any age, who resides with you for more than 50% of the tax year and is medically certified as disabled prior to age 19 or age 24 if disabled while a full-time student and for whom you have or will provide more than 50% of his/her support during the tax year. If age 24 or older, the dependent child cannot have a gross income in excess of the IRS exemption amount.
- Unmarried child between the ages of 19 and 24, or age 24 if gross income is not in excess of the IRS exemption amount, who resides with you for more than 50% of the tax year (temporary absences due to school attendance do not violate this residency rule), is a full-time student, as defined by the accredited institution of higher education and for whom you have or will provide more than 50% of his/her support during the tax year. You must supply the Benefits Office with documentation from the school verifying full-time student status. (Your student dependent child remains eligible during summer breaks from school provided that he/she will be attending school on a full-time basis during the fall term/semester.)

1. ○Add or ○Drop Dependent for: ☐Medical & Rx Plan ☐Dental Plan ☐Dependent Life

○ Add or ○ Change Life Beneficiary

RELATIONSHIP							
○ Legal Spouse	○ Full-Time Student (19 & older)	○ Child with Legal Guardianship	○ Father	○ Sister	○ Friend		
○ Child (under 19)	○ Disabled Child (19 & older)		○ Mother	○ Brother			

SS# (voluntary)	Last Name	First Name	Date of Birth	Gender ○M ○F

☐ Mailing Address Same as employee's	Address	City	State	Zip

2. ○Add or ○Drop Dependent for: ☐Medical & Rx Plan ☐Dental Plan ☐Dependent Life

○ Add or ○ Change Life Beneficiary

RELATIONSHIP							
○ Legal Spouse	○ Full-Time Student (19 & older)	○ Child with Legal Guardianship	○ Father	○ Sister	○ Friend		
○ Child (under 19)	○ Disabled Child (19 & older)		○ Mother	○ Brother			

SS# (voluntary)	Last Name	First Name	Date of Birth	Gender ○M ○F

☐ Mailing Address Same as employee's	Address	City	State	Zip

3. ○Add or ○Drop Dependent for: ☐Medical & Rx Plan ☐Dental Plan ☐Dependent Life

○ Add or ○ Change Life Beneficiary

RELATIONSHIP							
○ Legal Spouse	○ Full-Time Student (19 & older)	○ Child with Legal Guardianship	○ Father	○ Sister	○ Friend		
○ Child (under 19)	○ Disabled Child (19 & older)		○ Mother	○ Brother			

SS# (voluntary)	Last Name	First Name	Date of Birth	Gender ○M ○F

☐ Mailing Address Same as employee's	Address	City	State	Zip

4. ○Add or ○Drop Dependent for: ☐Medical & Rx Plan ☐Dental Plan ☐Dependent Life

○ Add or ○ Change Life Beneficiary

RELATIONSHIP							
○ Legal Spouse	○ Full-Time Student (19 & older)	○ Child with Legal Guardianship	○ Father	○ Sister	○ Friend		
○ Child (under 19)	○ Disabled Child (19 & older)		○ Mother	○ Brother			

SS# (voluntary)	Last Name	First Name	Date of Birth	Gender ○M ○F

☐ Mailing Address Same as employee's	Address	City	State	Zip

5. ○Add or ○Drop Dependent for: ☐Medical & Rx Plan ☐Dental Plan ☐Dependent Life

○ Add or ○ Change Life Beneficiary

RELATIONSHIP							
○ Legal Spouse	○ Full-Time Student (19 & older)	○ Child with Legal Guardianship	○ Father	○ Sister	○ Friend		
○ Child (under 19)	○ Disabled Child (19 & older)		○ Mother	○ Brother			

SS# (voluntary)	Last Name	First Name	Date of Birth	Gender ○M ○F

☐ Mailing Address Same as employee's	Address	City	State	Zip

Employee ID # 811

GROUP LEGAL (Paid 100% by Employee)	◯ ADD GROUP LEGAL	◯ DROP GROUP LEGAL

Group Legal allows you and your eligible dependents to receive certain personal legal services. The available benefits are comprehensive, but there are limitations and other conditions that apply. All benefits are available to you, your spouse and eligible dependents. This benefit covers telephone advice, office consultations and legal representation. This means you can talk to or visit with your Network Attorney at any time an event in your life creates legal concerns.

AUTHORIZATION

I authorize Maricopa County to take deductions from my paycheck and from any short-term disability payments I may receive, to pay for my benefit costs. Further, I authorize Maricopa County to take additional deductions from my paycheck and/or any short-term disability I may receive to reimburse Maricopa County for any benefits I and/or my dependent(s) were unauthorized or ineligible to receive because I provided inaccurate, incorrect and/or incomplete information to Maricopa County. Deductions to reimburse Maricopa County will be in accordance with the law. I also authorize the Employee Health Initiatives Department to send necessary personal information to my selected vendors to initiate and support my coverage.

By submitting my enrollment request, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents, as described in the Maricopa County Notice of Privacy Practices, with my health care providers and plan administrators which could include CIGNA HealthCare of AZ and CIGNA Dental, Walgreens Health Initiatives (WHI), Magellan Health Services, Delta Dental, Employers Dental Services (EDS), The Standard Life, EyeMed Vision Care, Sedgwick CMS, and Application Software Inc. I further agree to release Maricopa County and Maricopa County's health care providers and plan administrators from any liability for any good faith release of PHI in connection with my benefits or as otherwise authorized or required by law.

I certify to the best of my knowledge all information I have provided is accurate, correct and complete. I understand that I may be subject to disciplinary action up to and including termination for failing to provide accurate and complete information. I further understand and agree that I will be required to reimburse Maricopa County for any additional premiums and the full cost of claims paid as a result of providing inaccurate, incorrect and/or incomplete information.

Employee Signature: _____ Date: _____

DELIVERY INSTRUCTIONS

This form is used to report qualified status changes. This form may not be used for new or rehire enrollments (these enrollments must be completed online through Employee Self Service in PeopleSoft). Deliver this form to the Employee Health Initiatives Department or to your department's Human Resources (HR) Liaison or fax to 602-506-2354 (please keep a copy of your fax confirmation). Please keep a copy of your status change form containing a date stamp from the Employee Health Initiatives Department or from your HR Liaison. Do not deliver via interoffice mail, unless your form has been date-stamped by your department's HR Liaison. You may mail your form via U.S. Postal Service if it is postmarked no later than 30 days from the date of your qualified status change.

CONTACT INFORMATION
Maricopa County Employee Health Initiatives
301 West Jefferson, Suite 201, Phoenix, AZ 85003
Phone: 602-506-1010 Fax: 602-506-2354
Email: BenefitsService@mail.maricopa.gov

Revised: June 2008

FOR OFFICE USE ONLY

Effective Date:	Benefits Coordinator Name
Date Processed by Benefits Coordinator	